FIRE SEASON 2010

RETURNING Emergency Fire Fighters

Employees in this pay status are terminated at the end of their assignment, do not receive benefits, and cannot become permanent employees of the department.

You must complete the following forms:

- Returning EFF Employment From
- PERS Optional Membership Form & **Card (if option is yes)**
- 2010 W-4 Form
- Decedent's Warrant Form (Person designated to receive your last check in case of death)
- **Direct Deposit Form (optional)**

Reference Materials Included

- Incident Behavior Form
- State Fund 1st Report & Instructions
- EFF Information Sheet

Please check one of the following:

_____ I **do not** have any payroll/personnel information changes to make for the 2010 Fire Season from information previously provided to the Department.

_____ I **do** have some payroll/personnel information changes to make for the 2010 Fire Season:

Name: _____

Current Marital Status *Circle One:* Married Single

Address Change: _____
_____
_____

Emergency Contact Information: _____
_____
_____

Phone/s: (ICE)_____(h)_____(c)_____

_____ _____ _____
Employee Signature Print Name Date

_____ _____
Supervisor Signature Date

Rev. March 2010

MONTANA PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION
100 N PARK AVE STE 200 ~ PO BOX 200131
HELENA MT 59620-0131
(406) 444-3154 or toll free (877) 275-7372

PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS) OPTIONAL MEMBERSHIP ELECTION

This election must be completed legibly in ink, signed by both employee and employer, and received by MPERA within **90 days** of hire date if hired on or after July 1, 2009.

To be completed by **employer**:

Employee Name (Print) _____ Hire Date (Latest date employee started in this position) _____

Membership is **optional** for certain new employees; check the category that applies to this covered position.

_____ Non-member working 960 hours or less per fiscal year.
_____ Employee directly appointed by the Governor.
_____ Legislative branch employee working 10 months or less to perform work related to the legislative session.
_____ Chief administrative officer of a city or county.
_____ New employee of a county hospital or rest home.

Signature of Employer (required) _____ Date _____ Telephone Number _____

Agency _____ Agency No. _____

To be completed by **employee**:

Only non-members have an election. If you are currently an ACTIVE or INACTIVE member of PERS (anyone with contributions in PERS through this or any other agency), you may not elect out of PERS. If you are a RETIRED member of PERS, other restrictions apply. Contact your payroll clerk for appropriate forms.

The following restrictions apply:

- If I decline membership, I may not become a member while still employed in this position. However, if I ultimately work more than 960 hours in a fiscal year, cumulative of all PERS employers, membership becomes mandatory and I must begin making retirement contributions starting with hour 961.
- If I decline membership, terminate employment, and become employed in another optional position within 30 days of termination, I may not become a member in the second optional position.
- If I decline membership, terminate employment, and become employed in another optional position 30 days or more after my termination, I am allowed a new election.
- If I decline membership, I will not receive membership service or service credit for employment for which membership was declined.
- If I subsequently accept employment in a position for which retirement is mandatory, I must become a member regardless of this election.
- If any information in this form conflicts with statute or rule, the statute or rule will apply.

I am **not** an active, inactive or retired member of PERS. I understand that I have the option to choose PERS membership due to employment with this agency.

☐ **I decline PERS membership**

☐ **I elect PERS membership (Complete a membership card and attach)**

Signature of Employee (required) _____ Date _____ Social Security Number* _____ Date of Birth _____

Return original to MPERA at above address. Employer Retains copy for records.

*Mandatory for ID purposes § 19-2-403(7), MCA

MPERA Use:
Entered by_____
Date_____

Rev 07/2009

Form W-4 (2010)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E ____
F	Enter "1" if you have at least $1,800 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children.	G ____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $18,000 ($32,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2010

1 Type or print your first name and middle initial.	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2010, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(Form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: $11,400 if married filing jointly or qualifying widow(er) $8,400 if head of household $5,700 if single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.)	5	$
6	Enter an estimate of your 2010 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,650 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3."	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is ***less than*** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $6,000	0
7,001 - 10,000	1	6,001 - 12,000	1
10,001 - 16,000	2	12,001 - 19,000	2
16,001 - 22,000	3	19,001 - 26,000	3
22,001 - 27,000	4	26,001 - 35,000	4
27,001 - 35,000	5	35,001 - 50,000	5
35,001 - 44,000	6	50,001 - 65,000	6
44,001 - 50,000	7	65,001 - 80,000	7
50,001 - 55,000	8	80,001 - 90,000	8
55,001 - 65,000	9	90,001 -120,000	9
65,001 - 72,000	10	120,001 and over	10
72,001 - 85,000	11		
85,001 -105,000	12		
105,001 -115,000	13		
115,001 -130,000	14		
130,001 - and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$550	$0 - $35,000	$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

LEGAL DESIGNATION OF PERSON AUTHORIZED TO RECEIVE DECEDENT'S WARRANTS

Instructions for Employee

1. Complete the Beneficiary Designation portion of this form. This form must be typed or printed legibly in ink.
2. Provide designee's full legal name (example "Mary Lynn Smith"). The designee name cannot be "Mrs. John E. Smith" or "To the Estate of Jane Smith".
3. No erasures or corrections in the designee's name can be accepted. If an error is made, complete a new form.
4. Inform your HR/payroll personnel when designee's address changes.
5. Sign this form in ink and submit to your agency HR/payroll personnel.
6. Designee may be changed at any time by completing another form and submitting to your agency HR/payroll personnel. You are requested to update your designee every calendar year.

Beneficiary Designation For Decedent's Final Warrants

Pursuant to §2-18-412, MCA, I hereby designate the following person who, notwithstanding any other provision of law, shall be entitled upon my death to receive all state warrants, excluding payment of death benefits and refund of employee retirement contributions, payable to me as a result of my employment with the State of Montana had I survived.

All information is **required**.

Name of Designee _____
First Middle Last

Mailing Address _____
Street or PO Box City State Zip Code

Social Security Number _____ Date of Birth _____

My signature on this document indicates:

1. I understand this is a legally binding document.
2. I hereby revoke any previous designation filed by me.
3. If the above named designee cannot be contacted within sixty days after the date of my death, this designation shall be void and the warrant will be reissued to my estate.
4. This designation will remain in full force and effect until revoked by me in writing.

Employee Name _____ _____
First Middle Last Social Security Number

_____ _____
Employee Signature Date

Instructions to Employer

Review above information for proper completion by employee and reaffirm to employee, this is a **legally binding document**. Place document in employee's file. Have your employees periodically review their designation.

1. Upon death of employee, complete the information below. The Certifying Officer should be the agency head or personnel officer. ***Carefully follow the checklist for Deceased Employee available on the State Human Resources Division website.***
2. Send two copies of this form to the SHRD Human Resources Information Services Bureau and retain original in employee's file.
3. If death occurs after the warrant has been issued but before it has been negotiated, recover the warrant (if possible) and submit to the SHRD Human Resources Information Services Bureau.

_____ _____ _____
Date of Death Certifying Officer Signature Date

FOR USE BY DEPARTMENT OF ADMINISTRATION - WARRANT WRITING

Agency Phone # _____ Agency Contact _____

Vendor # _____ Beneficiary Name _____ Employee Name _____

Approved by _____ Voucher # _____
Date _____ Done By _____
Date _____

Approved By _____ Journal # _____ Replacement # _____
Date _____ Date _____ Date _____

Standard Form 1199A
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed for will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Sufffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed Salary/Mil. Civilian Pay
- ☐ Mil. Active _____
- ☐ Mil. Retire. _____
- ☐ Mil. Survivor _____
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENRATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or record-keeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

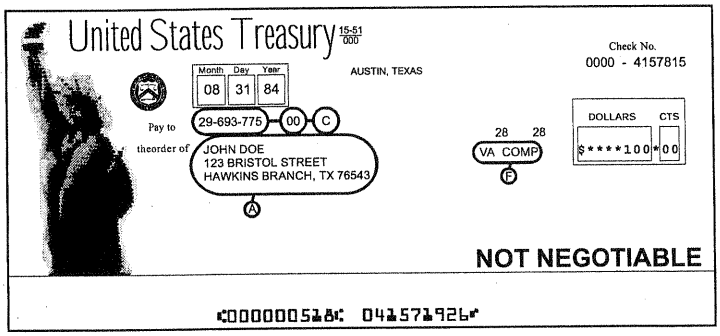
INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

Ⓐ Be sure that the payee's name is written exactly as it appears on the check. Be sure current address is shown.

Ⓒ Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.

Ⓕ Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until canceled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete the new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

Incident Behavior

Fireline Handbook, Chapter 6 – Common Responsibilities
Contractors, Volunteers, Casual Firefighters

Inappropriate Behavior:

It is extremely important that inappropriate behavior be recognized and dealt with promptly. Inappropriate behavior is all forms of harassment including sexual and racial harassment. **Harassment in any form will not be tolerated**. When you observe or hear of inappropriate behavior you should:

- Inform and educate subordinates of their rights and responsibilities
  Tell the harasser to stop the offensive conduct.
- Provide support to the victim.
- Report the incident to your supervisor and the individuals' supervisor, if the behavior continues. Disciplinary action may be necessary.
- Develop appropriate corrective measures.
- Document inappropriate behavior and report it to the appropriate incident manager or agency official.
- While working in and around private property, recognize and respect all private property.

Drugs and Alcohol:

- Non-prescription unlawful drugs and alcohol are not permitted at the incident. Possession or use of these substances will result in disciplinary action.
- During off-incident Rest & Recuperation periods, personnel are responsible for proper conduct and maintenance of fitness for duty. Drug or alcohol abuse resulting in unfitness for duty will normally result in disciplinary action.
- Be a positive role model. Do not be involved with drug or alcohol abuse.
- Report any observed drug or alcohol abuse to your supervisor.

I have read and understand the above described incident behavior responsibilities:

_____ _____

Signature Date

FIRST REPORT INJURY & OCCUPATIONAL DISEASE REPORTING
MONTANA STATE FUND

- **All DNRC personnel**, including EFF's, must fill out a First Report of Injury form for every on-the-job injury. The form must be submitted for all injuries in order to protect the employee's right to benefits in the event a seemingly minor injury develops into a more serious condition.
- **Employees** should notify their supervisor of any on-the-job injury immediately. **Employers (supervisors)** must complete and submit the First Report of Injury form **within 6 days** of notification to the supervisor of the injury. It is the **supervisor's** responsibility to see that the report is submitted.
- Incomplete forms will not be processed until supervisor can be contacted to supply missing information.
- On fire assignments, the employee's "supervisor" is his/her immediate supervisor at the incident. If this individual is not a DNRC employee, it is then the injured employee's responsibility to submit the First Report, with the fire supervisor's signature. Contact home unit as soon as possible to inform regular supervisor of the injury.
- Policyholders may be fined $250 to $500 per late report of injury at the discretion of the Department of Labor & Industry.
- An 800 number has been established specifically to assist DNRC's **Fire Fighting Personnel** in reporting first injuries: **1-800-332-6102 Team 6.** For further assistance, you may also contact the following:
  1-800-332-6102, Ext. 6482 (Mitzie Saltzman, Montana State Fund)
  1-406-444-6673 (Kelly Bishop, DNRC, Personnel)
- A hard copy of the First Report form may be found in the DNRC Fire & Aviation Management Bureau's 300 Manual or may be obtained from any DNRC area office.
- An electronic version may be found at: http://www.montanastatefund.com/wps/portal
  Go to Reporting an Injury under Quicklinks
  Go to First Report of Injury Form (ms-word) (right hand vertical column)
  You can either complete online or print, complete and fax.

INSTRUCTIONS FOR FIRST REPORT

> Fill out all sections, except "Insurer Only" section, as completely and legibly as possible.
> Employee and supervisor should both sign, if available. Supervisor must sign before submitting.
> **Submit this form within the 6 day limit even if employee is not available to sign, ie: hospitalized, etc.**
> **Helpful Hints:**

- DNRC's federal tax ID # is **81-0302402**.
- Use payroll classification code **9422** for firefighters.
- For "Employer mailing address", use the main Helena DNRC address: P.O. Box 201601, Helena, MT 59620-1601. For phone number, use a number at which the supervisor can be reached.
- For "Location of Operation", use the employee's home unit address.
- Leave blank the following boxes, as they do not apply to DNRC:
  "Employer is a sole proprietorship, partnership, corporation, limited liability company."
  "Injured worker is a sole proprietorship, partnership, corporation, limited liability company."
  "Insurance Agent's name"
  "Insurance Agency"
  "Agent's Telephone Number"

TWO OPTIONS FOR SUBMITTING FIRST REPORT

1.) FAX TO: 1-406-444-2684, Attn: Kelly Bishop. (preferred option) Payroll personnel will check the report to verify completion and forward to Montana State Fund immediately.

2.) If you do not have access to a fax machine, you may phone in the report to Montana State Fund directly at 1-800-332-6102-Team 6.

MONTANA STATEFUND
P.O. Box 4759
Helena, MT 59604-4759

First Report

Fax: 406-444-5963
Voice: 800-332-6102

Claims Examiner Date Stamp

Worker

Dept Code: (if applicable)

Last Name	First Name	M.I.	Date of Birth	Social Security Number
				- -

Home address	City	State	Postal Code
			-

Phone Number	Education	Gender	Marital Status	Number of Dependents
( ) -	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Unknown ☐ Female	☐ Married ☐ Separated ☐ Not Married ☐ Unknown	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	1 Date / Amount /	2 Date / Amount /	3 Date / Amount /	4 Date / Amount /

Employment Status	Number of days worked per week:	Wage:
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer		☐ Hour ☐ Week ☐ Month ☐ Other: ☐ Day ☐ Bi-weekly ☐ Year

In addition to gross earnings cited above worker received:	Estimated value if any:	Is sick leave available?	Used?
☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:		☐ Yes ☐ No	☐ Yes ☐ No

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to work	Full wages paid for date of Injury?	Salary continued?
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ yes ☐ No	☐ Yes ☐ No

Accident Description

Description of Accident (continue on separate sheet if necessary)

Cause of Injury	Part of Body	Nature of Injury	Date and Time of Injury
			/

Date disability began:	Date of Death:	Occupation:	Names of witnesses: 1) 2)

Accident on employer's premises?	Accident address or location: City: State: Postal code: -
☐ Yes ☐ No	

Date employer notified:	Accident reported to:	Safety equipment provided?	Safety equipment used?
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number
			-	( ) -
Hospital Name	**Address**	**State**	**Postal Code**	**Phone Number**
			-	( ) -

Type of initial medical treatment received: ☐ No treatment ☐ Emergency room ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ Hospital

Signature

This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be subject to civil and criminal penalties.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.)

Mailing Address	City	State	Postal Code	Phone Number
			-	( ) -

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured?
		☐ Yes ☐ No

Employer is a	Injured worker is a	
☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ A member of the employer's (sole proprietor or) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ? ☐ yes ☐ no

Insurance Agent's Name	Insurance Agency	Agent's Telephone Number
		( ) -

Prepared by:	Official title:	Date:

Payroll Classification Code under which you report employee's wages:

Authorized Employer's Signature:_____ Date:_____

Insurer Only

Claim Administrator's Claim Number:	Date reported to Claim Administrator:	The above information is correct with the following exceptions: ☐ (Attach extra sheets if box at right is checked)

Third Party Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:

Insurer's Name:	Third Party Administrator's FEIN:

Policy Number:	Policy Effective Date:	Policy Expiration Date:

Montana DNRC Emergency Firefighter (EFF) Information Sheet

HIRING

The State of Montana DNRC hires casuals, or temporary employees, as state EFF's. They are **not** federal AD's. All hiring paperwork is normally completed and on file at the home unit prior to dispatch to an incident.

Workers Compensation Insurance: EFF's are covered under MT Workers Compensation Insurance (MT State Fund: 1-800-332-6102, team 6). See attached *First Report of Injury* and reporting instructions.

Taxes & Benefits: State and federal taxes are deducted from EFF gross earnings and state unemployment insurance is paid by the state. FICA (federal social security) taxes are **not** deducted from EFF earnings. EFF's are not entitled to sick or annual leave and are not required to participate in the state retirement plan unless working more than 960 hours per year.

Entitlements: If incident commissary (National commissaries are no longer available; therefore, incident commissary will be very limited, see the NRCG supplement to Chapter 10 of the Interagency Incident Business Management Handbook (IIBMH), Section 14.3) is available, EFF's are granted commissary privileges in accordance with instructions in the IIBMH. EFF's earn overtime on greater than 8 hours in a day and greater than 40 hours in a week. Though time is kept on the OF-288, overtime does not need to be computed on an incident; it will be figured when EFF time reports are processed by DNRC Payroll. EFF's are **not** entitled to hazard pay or any other pay differentials. EFF's are **not** entitled to be paid for R&R upon return home. If the IC feels R&R is warranted, it must be provided by the incident prior to Demob.

Pay Rates: EFF pay rates are determined by the nature of the work assigned. See the NRCG supplement to Chapter 10 of the IIBMH at the following website for Montana EFF pay rates. See NRCG supplement to Chapter 50 for additional EFF info. http://www.fs.fed.us/r1/fire/nrcg/Committees/business_committee.htm

TRAVEL

When in travel status, occasionally meals or lodging expenses must be paid out of pocket. Reimbursement for such expenses will be in accordance with State of Montana Travel and Reimbursement Policies and State Per Diem Rates. MT state per diem rates (in state or out of state, as applicable) always apply, regardless of host agency or location of incident. Lodging reimbursement rates are generally up to $70/night plus tax. Lodging receipts must be submitted; reimbursement is at actual cost. Requests for reimbursement of travel expenses must be in the form of a Travel Expense Voucher, submitted to the home unit. Montana travel and per diem policies and forms can be found at the following website: http://dnrc.mt.gov/forestry/fire/business/forms.asp. Higher meal rates may be available in-state for suppression personnel, please contact your hiring office for more information and Chapter 310 of the DNRC Fire Business (300) Manual.

MT Per Diem meal rates (flat rates, receipts not required):

In state:	Breakfast	$5.00	Out of state:	Breakfast	$7.00
	Lunch	$6.00		Lunch:	$11.00
	Dinner	$12.00		Dinner:	$18.00
		$23.00 per day			$36.00 per day

VEHICLE USE

If an EFF is not traveling to the incident in a local government vehicle or a DNRC vehicle, the dispatch office should arrange for travel to and from the incident. If an EFF must use a personal vehicle to travel to and from an incident, the vehicle will be reimbursed for mileage at state rates. This request for reimbursement should be documented on a Travel Expense Voucher. If the vehicle is specifically ordered on a Resource Order for use on the incident, it should be signed up on an EERA at the home unit and paid at a daily and/or mileage rate, as applicable.

PAYMENT DOCUMENTS

ALL PAYMENTS FOR EFF'S AND/OR LOCAL GOVERNMENT FORCES ARE PROCESSED THROUGH THE HOME UNIT (DNRC HIRING OFFICE). The crew representative (or individual) must bring the original payment documents back to the home unit for processing. MT DNRC is the only payment agency for EFF's and local government equipment from Montana.

HOME UNIT CONTACT INFORMATION (hiring Land Office or Unit Office)

Address: _____ Phone: _____

_____ Contacts: _____

_____ _____

DNRC hiring official: Attach blank First Report of Injury and reporting instructions to this form, and give to each EFF at time of hire.
EFF: Carry this form and a copy with you on incident assignments. Present copy to Finance Section.